

CARE COORDINATION ACROSS THE CONTINUUM POLICY RECOMMENDATIONS

A WHITE HOUSE CONFERENCE ON AGING POLICY SOLUTIONS FORUM

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Introduction Most people now live long and healthy lives, with average life expectancy well into the 70's. But, no matter how carefully we protect our health, eventually, each of us will become sick, frail, or disabled from one or more conditions that result in ongoing illness leading to death. At this time of life, seamless coordination of comprehensive, reliable, and readily accessible medical care and supportive services over time and across settings is an essential hallmark of quality of care. However, current healthcare services conform closely to a patchwork of federal and state reimbursement systems and to the convenience of the providers; are episodic and marked by errors, inefficiency, duplication of tests and services and gaps in needed services; and ignore the long-term care, personal, social, and housing needs of this end of life population.

How Can We Achieve Reform? The major leverage in reform is to rearrange payment and practice patterns to reward only those providers delivering comprehensive, coordinated and continuous services. Standards of quality and federal and state payment policy should require evidence-based medical interventions, continuity across settings and time, responsiveness, symptom relief, family support, and advance care planning. The WHCoA Continuity of Care Policy Solutions Forum panelists and others propose the following **SEVEN** specific recommendations for the White House Conference on Aging.

Recommendation 1: PAY FOR CONTINUITY

- CMS should pay current aggregate payment levels only for comprehensive medical services following patients across settings and time, through to death. Uncoordinated, fragmented care should receive discounted reimbursement.
- CMS should set risk adjustment rates for providers that reflect the real costs of providing comprehensive, coordinated, longitudinal chronic care that allows flexibility in the configuration of the services delivered.

- CMS should sponsor regional planning that builds from the priorities of the affected chronically ill population and ensures that gaps, duplications, and inappropriate services are corrected.

Recommendation 2: REQUIRE THESE CRITICAL ELEMENTS OF OPTIMAL CHRONIC ILLNESS COORDINATED CARE

- (1) Medical, nursing, and psycho-social services;
- (2) Advance care planning addressing future care issues;
- (3) Mobilization of most routine services to where the patient is: at home, congregate living facility, or nursing facility;
- (4) Adherence to evidence-based standards and guidelines for treatments, medication therapy management, and services;
- (5) Delivery of ongoing education, training, and support of patients and caregivers for self-management;
- (6) 24/7 telephone access to appropriate clinical help, always with access to the patient's record;
- (7) Rapid response by appropriate clinicians for urgent situations at home; and
- (8) Implementation of continuous quality improvement to ensure reliable excellence.

These hallmarks of quality care for those with serious chronic illness should be part of provider conditions of participation, certification of provider quality, reports of quality to the public, and payment for performance programs.

Recommendation 3: ENSURE CONTINUITY OF PATIENT INFORMATION ACROSS SETTINGS AND TIME

Federal agencies funding electronic health record development should require the inclusion of standardized functional and social information (including advance care plans) and that these records be accessible across multiple providers, care settings, and the internet.

Congress should also mandate and set a timeline for all healthcare providers to implement a standardized electronic healthcare record system universally compatible and internet accessible to providers and consumers.

Recommendation 4: FUND REGIONAL DEMONSTRATIONS

Congress should authorize CMS, HRSA, ASPE, AHRQ, DVA, and other federal agencies to administer region-wide demonstrations of optimal service planning and care delivery for the advanced chronic illness population.

**Recommendation 5: REQUIRE ANNUAL REPORT ON FAMILY
CAREGIVERS AND LTC WORKFORCE**

Congress should require the Department of Labor to monitor and issue an annual report on the long-term care workforce; caregiver economic and social support issues, including family caregivers as a workforce issue; and the potential effects of alternative policy decisions on these workers, including on retirement.

**Recommendation 6: REQUIRE ANNUAL REPORT ON PROGRESS TOWARD A
COORDINATED CARE SYSTEM**

Congress should require an annual report on progress toward the development of a reliable, sustainable, longitudinal care “system” for this population, including progress in overcoming the barriers to continuity of care arising from reimbursement patterns.

**Recommendation 7: ENGENDER PUBLIC DEBATE ON A NATIONAL LONG
TERM CARE AND CAREGIVER AGENDA**

Congress should work to engender broad interest, activism, and debate among the public, these patients and their family caregivers, and policy-makers on a national agenda for care arrangement in the last phase of life.

Conclusion. We have the extraordinary historical opportunity to grow old before becoming ill and dying. However, we also have the challenge of learning to live well, often for some years, with progressive and eventually fatal illnesses. If we learn to engineer care arrangements efficiently, target services by need, require continuity and responsive services, and support family and paid caregivers, we can provide the kind of care we can all count on when we need it most.